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Goal conflict when making decisions for others

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ABSTRACT

Some of life's most important and difficult decisions are made on behalf of others. However, little is known about how goal conflict influences high-stakes decisions made on behalf of others. A nationally representative sample of U.S. healthcare providers (n = 502) read a statement presenting curative and palliative care goals as conflicting or complementary. We predicted and found that providers who received a goal conflict (vs. complementary) message perceived greater conflict, and rated palliative goals as less important. Providers who received a goal conflict (vs. complementarity) message also rated curative goals as less important. Moreover, there was an indirect link from goal conflict condition to willingness to provide palliative care, mediated by perceived goal conflict. A self-affirmation manipulation reduced providers' willingness to provide palliative care, but did not influence the effect of goal conflict on decision-making. Findings suggest that goal conflict is consequential for high-stakes decisions made for others, and that goal conflict (vs. complementarity) lowers importance of, and increases disengagement from, conflicting goals.

1. Introduction

Some of life's most important and difficult decisions are made on behalf of others. For example, a parent may decide whether to send a child to public school or to private school, a physician may recommend palliative care and/or painful chemotherapy treatments, a psychiatrist may order a distressed patient to involuntary hospitalization or choose to continue outpatient treatment, and a health surrogate may decide whether a loved one should continue with life-sustaining treatments or institute a Do-Not Resuscitate Order. Such decisions are difficult because they involve tradeoffs with serious consequences. Emerging theoretical perspectives suggest that goal pursuit is carried out with assistance from other people: individuals help each other to pursue goals or pursue goals together (Fishbach & Tu, 2016; Fitzsimons, Finkel, & Vandellen, 2015; Orehek, Forest, & Barbaro, 2018). However, little is known about how people negotiate goals in the context of making high stakes decisions *for* others.

Understanding how individuals negotiate conflicting goals in the context of making high stakes decisions on behalf of others is important to understand because decision making on behalf of others is prevalent and consequential. Individuals often make decisions on behalf of others, particularly when others lack the capacity to make decisions for themselves (e.g., Shah, Rasinski, & Alexander, 2015; Shalowitz, Garrett-Mayer, & Wendler, 2006; Vig, Starks, Taylor, Hopley, & Fryer-Edwards, 2007), or when they lack the expertise to make those decisions (as may be perceived by healthcare providers who make decisions on behalf of patients rather than engaging in shared decision making; Degner & Sloan, 1992; Gravel, Légaré, & Graham, 2006; Murray, Pollack, White, & Lo, 2007). Moreover, the person making the decision often experiences serious emotional repercussions as a result of the choice (Azoulay et al., 2005; Vig, Starks, Taylor, Hopley, & Fryer-Edwards, 2007; Wendler & Rid, 2011). Indeed, decision-making sometimes comes with a higher emotional cost when deciding for others than when deciding for the self (Zikmund-Fisher, Sarr, Fagerlin, & Ubel, 2006), especially if the decision-maker is interdependent with the other person (Polman & Vohs, 2016). The present research aimed to better understand the influence of goal conflict on high stakes decision making for others by investigating healthcare providers' decision to provide palliative care to patients.

1.1. Goal conflict

People have many goals, which often come into conflict with one another (Kruglanski et al., 2002; Neal, Ballard, & Vancouver, 2017; Orehek & Vazeou-Nieuwenhuis, 2013; Vancouver, Weinhardt, & Schmidt, 2010). Two or more goals come into conflict when a

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behavioral means to one goal deters or precludes achieving the other, or because inadequate resources exist to pursue both goals (Emmons & King, 1988; Kruglanski et al., 2013; Orehek & Vazeou-Nieuwenhuis, 2013). At the individual decision-making level, such conflict can preclude successful pursuit of both goals, and may require a choice to pursue one goal at the expense of another (Achtziger, Gollwitzer, & Sheeran, 2008; Goschke & Dreisbach, 2008; Köpetz & Orehek, 2015; Shah, Friedman, & Kruglanski, 2002). Although in some goal conflict situations, it is possible to identify means that can facilitate both goals (Chun, Kruglanski, Sleeth-Keppler, & Friedman, 2011; Kruglanski et al., 2013; Orehek, Forest, & Wingrove, in press), such choices are often not readily available (Köpetz, Faber, Fishbach, & Kruglanski, 2011). Because of this, people often pursue the more valued goal, inhibiting the activation of conflicting goals (Achtziger, Gollwitzer, & Sheeran, 2008; Fishbach & Zhang, 2008; Gollwitzer, Heckhausen, & Steller, 1990; Köpetz, Kruglanski, Chen, & Orehek, 2008; Kruglanski et al., 2002) or disengaging from pursuit of those goals (Orehek, Bessarabova, Chen, & Kruglanski, 2011; Wrosch, Scheier, Carver, & Schulz, 2003; Wrosch, Scheier, Miller, Schulz, & Carver, 2003). This is particularly likely when one goal is prioritized over the other (Chun, Kruglanski, Sleeth-Keppler, & Friedman, 2011; Köpetz, Faber, Fishbach, & Kruglanski, 2011; Shah, Friedman, & Kruglanski, 2002), and can lead to motivated distortion of information in order to justify the chosen alternative (Bélanger, Kruglanski, Chen, & Orehek, 2014; Bélanger, Kruglanski, Chen, Orehek, & Johnson, 2015; Kruglanski & Orehek, 2007). Thus, unless a choice is readily available that satisfies both currently activated, important goals, a person facing a conflict between two goals inhibits the activation of the lower priority goal, behaviorally disengages from its pursuit, and justifies their choice in favor of the higher priority goal through motivated reasoning. Despite extensive research on negotiating and resolving goal conflict at the individual decision-making level, there is a dearth of evidence on how individuals resolve goal conflict – either their own, or their perception of goal conflict experienced by the individual for whom they are making the decision – when making decisions on behalf of others.

1.2. Conflict between curative and palliative care

The choice healthcare providers' face between providing curative and palliative care in healthcare settings is a prime example of goal conflict, with consequential implications for the health and well-being of others. Palliative care is treatment designed to manage pain and symptoms and provide psychosocial support in advanced illness or illness with high symptom burden, and can be administered even in conjunction with curative care (CAPC, 2015). In part due to the shortage of palliative specialists (Dharmarajan, Wei, & Vapiwala, 2015), palliative care requires participation from providers at all levels, including not only physicians, but also nurses, nursing aids, medical support team members, pharmacists, and paramedics (Ahsberg & Carlsson, 2014; Barrett & Connaire, 2016; Kent et al., 2016; Morrison, Wallenstein, Natale, Senzel, & Huang, 2000; Wiese et al., 2009). Palliative care decision making among healthcare providers is an ideal context in which to examine robustness of social psychological theory, because it involves high-stakes decisions made in a uniquely emotionally-laden environment, as well as decisions made on behalf of others (Ferrer, Padgett, & Ellis, 2016).

The perceived conflict between curative and palliative care is an important real-world context to study goal conflict when making decisions on behalf of others for several reasons. First, healthcare providers tend to assume that such goal conflict exists, and prioritize curative goals, which suggests that they may be less likely to provide palliative care and delay conversations about prognosis and palliative care options (Bakitas, Lyons, Hegel, & Ahles, 2013; CAPC, 2011; Gawande, 2014; Kelley & Morrison, 2015; Mollica et al., 2018; Peppercorn et al., 2011). Unfortunately, many providers erroneously believe that palliative care is appropriate only at end-of-life, and that patients may lose hope if it is provided (CAPC, 2011; Garrett, Chinn, Liu, Klabunde, & Kahn, 2014; Schenker et al., 2013); thus, perceived conflict among curative and palliative goals may reflect conflict experienced by the provider, as well as perceived conflict projected onto the patient. Second, no research has experimentally investigated the effect of curative-palliative conflict on healthcare providers' decisions about whether to provide or refer patients to palliative care.

Finally, despite empirically supported benefits and expert recommendations, palliative care is underutilized in the U.S. (Cohen et al., 2008; Ferrell & Grant, 2014; Ferrell, Temel, Temin, & Smith, 2016; Ferris et al., 2009; Gidwandi et al., 2016; Graham, 2014). For example, cancer patients often receive chemotherapy within days of death without accompanying palliative care (Peppercorn et al., 2011), and dementia patients often undergo intensive and ineffective medical interventions in the last months of life (Mitchell et al., 2009). Palliative care has been shown to reduce symptom burden, lessen depression and anxiety, and improve physical and functional well-being among patients (Bakitas et al., 2015; El-Jawahri, Greer, & Temel, 2011; Kavalieratos et al., 2016; Temel et al., 2010; Wright, Zhang, & Ray, 2008) and their caregivers (Dionne-Odom et al., 2015; El-Jawahri, Greer, & Temel, 2011; Wright, Zhang, & Ray, 2008). Palliative care also reduces pursuit of aggressive treatment options that are unlikely to be effective (Adelson et al., 2017; Temel et al., 2010). Accordingly, although most adults in the U.S. have limited knowledge of palliative care, the majority would want it for themselves or family members once they read the definition (CAPC, 2011). Critically, contrary to the perception that palliative care conflicts with curative care, palliative care does not hasten death and *may even extend life* for patients with terminal cancer (Bakitas et al., 2015; El-Jawahri, Greer, & Temel, 2011; Temel et al., 2010; although see Kavalieratos et al., 2016), and pain management strategies (including opioid analgesics) *do not interfere with curative care* or lead to drug abuse or mortality (Novak, Nemeth, & Lawson, 2004).

Thus, the decision whether to provide palliative care is an ideal context in which to study how goal conflict is negotiated and resolved in high stakes decision-making on behalf of others. Provision of palliative care involves serious consequences for the recipient of care: it can influence their pain, comfort, and longevity. The decision is commonly made by a variety of healthcare providers on behalf of patients. In addition, healthcare providers perceive a conflict between palliative care and curative care, even though the reality is that no such conflict exists. Therefore, we can take advantage of this pre-existing decision domain in order to manipulate perceptions of goal conflict that have the potential to serve as useful interventions that could serve as ways to improve treatment.

1.3. Making decisions for other people

The preceding sections reviewed evidence and theory in support of the notion that goal conflict influences individual decision-making when making choices for oneself. However, if such research is to be applied to cases in which people make important decisions for others, then it is important to consider the current understanding of how making decisions for other people may differ from making decisions for oneself. As stated, people often make decisions on behalf of others. Moreover, one person can set goals for another, and can engage in decisions and actions that help close others to achieve those goals (Fishbach & Tu, 2016; Fitzsimons, Finkel, & Vandellen, 2015; Orehek & Forest, 2016).

The available research suggests that people making decisions for others focus more on potential gains (Polman, 2012a, 2012b), are more indulgent (Laran, 2010), perceive fewer tradeoffs (Kray, 2000), and engage in more pre-decisional motivated reasoning (Polman, 2010), than when making decisions for themselves. When making a decision for someone else, people make more creative (Polman & Emich, 2011) and idealistic (Laran, 2010; Lu, Xie, & Xu, 2013) choices than when